Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
RENAISSANCE-DALLAS
PO BOX 11527
HOUSTON TX 77293

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-08-0472-01

MFDR Received Date
SEPTERMBER 20, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the position of Renaissance Hospital that the Respondent has not reimbursed these services at a fair and reasonable rate as required in TDI-DWC Rule §134.401… It is our position that the Carrier has failed to prove our PAF is not fair and reasonable, and thus Renaissance Hospital has met it's 'burden of proof' in this case."

Amount in Dispute: $7,710.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier, or its agent, did not respond to the initial request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2007	Outpatient Surgery	$7,710.93	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on September 20, 2007.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contract/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 900-021 – Any Network Reduction in accordance with the Network referenced above.

- W1 – Workers Compensation State Fee Schedule Adjustment.
- 855-002 – Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines.
- W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement.
- 850-054 – The recommended payments above reflect a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in Section 413.011(D) of the Texas Workers' Compensation Act.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement. This change to be effective 61/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. On October 27, 2011 the Division requested a copy of the contract between the information/voluntary network and Renaissance-Dallas as described by Texas Labor Code § 413.011(d-1)(2) and documentation to support that Renaissance-Dallas was notified in accordance with 28 Texas Administrative Code §133.4. The insurance carrier's representative submitted a response to the Divisions request stating, "Respondent did not reduce this medical bill pursuant to a network." The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report and anesthesia record, the requestor did not submit a copy of the post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
5. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Our company has purchased both hospital-specific and national average-specific payment statistics knows as Med Par Data from Cleverly and Associates, a nationally-recognized third-party vendor of payment information. Based on this data, we have established a Payment Adjustment Factor (PAF) to be applied to our hospital-

specific Medicare Outpatient Prospective Payment System (OPPS) reimbursement rate, and have determined this to be our interpretation and application of Fair and Reasonable. ”

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 12, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.